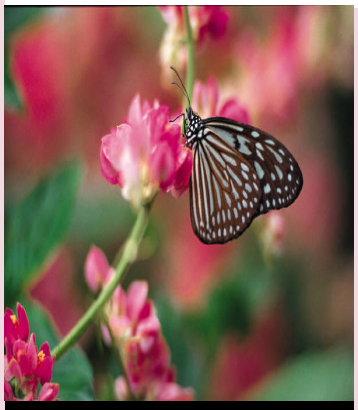
Volume 11, Issue 2



BUREAU TALK

Volume 11. Issue 2 APRIL 2011 http://health.mo.gov/safety/homecare

Inside this issue:

New Website Domain

The Bureau of Home Care and Rehabilitative Standards strive to keep agencies informed of new information or any changes that would impact the agencies in our state. It is that time again.

The department is springing forward with the launch of our new website domain, **health.mo.gov** effective March 14, 2011.

Along with the change, all department email addresses will be changing from @dhss.mo.gov to @health.mo.gov. All email coming from the Department of Health and Senior Services (DHSS) will come from a @health.mo.gov address. The old email addresses will have a redirect on them to assist with the transition.

Influenza Vaccinations

The bureau was recently informed of a new "Association for Professionals in Infection Control and Epidemiology (APIC)" position statement regarding the requirement of all healthcare personnel (HCP) to be vaccinated against influenza. The position statement states: "APIC recommends that acute care hospitals, long term care, and other facilities that employ healthcare personnel (HCP) require annual influenza immunization as a condition of employment unless there are compelling medical contraindications. This requirement should be part of a comprehensive strategy which incorporates all of the recommendations for influenza vaccination of HCP of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) for influenza vaccination of HCP…"

For more information you can access the APIC website at www.apic.org.

Mandatory Reporting

The Missouri Revised Statute, Chapter 383, Section 383.133 titled Malpractice Insurance, addresses the requirement of reporting " ...to the appropriate health care professional licensing authority any disciplinary action against any health care professional or the voluntary resignation of any health care professional against whom any complaints or reports have been made which might have led to disciplinary action. "

The statute also requires these reports be submitted within "fifteen days of the final disciplinary action... "

Chapter 383, Section 383.130 Definitions states, " Disciplinary action, any final action taken by the board of trustees or similarly empowered officials of a hospital....to reprimand, discipline or restrict the practice of a health care professional. Only such reprimands, discipline, or restrictions in response to activities which are also grounds for disciplinary actions according to the professional licensing law for that health care professional shall be considered disciplinary actions for the purposes of this definition; ... "

The bureau contacted Legal Counsel of the State Board of Nursing for further clarification on "disciplinary action" and was informed that if the employer provides EAP (employee assistance program) or such things as in-services, extra training, counseling, etc. to an employee , this is not considered "disciplinary action".

Section 383.130 also defines health Care Professional as, "...a physician or surgeon...or a nurse licensed under the provisions of chapter 335, RSMo, while acting within their scope of practice; ... "

Surveyors will be citing if, during the survey process, it is identified that disciplinary action has occurred against a health care professional but the agency failed to provide the required information to the appropriate professional licensing authority within the specified time frame.

New Advisory Council Members

The Bureau of Home Care and Rehabilitative Standards would like to extend a big WELCOME to the newest members of both the Home Health and Hospice Advisory Councils. These council members represent a diversity of agencies in the state of Missouri and will serve for a period of three years with home and five years with hospice. The Bureau would also like to extend our sincere thanks & appreciation to those members whose terms have expired, as well as those who continue to carry out their present term.

Home Health Advisory Council

The newest members:

Lisa Musgrave from Kansas City:	Hospital Based agency
Dorothy Hamilton from St. Louis:	Consumer representative for the State of Missouri
Teresa McCulloch from Kennett:	Voluntary non-profit agency
Mary Fetters from Joplin:	Private non-profit agency
Evelena Sutterfield from Kahoka:	Public Sponsored agency

Former members:

Marcia Eckrich from St. Louis:	Voluntary non-profit
Angy Littrell from Columbia:	Private non-profit
Carol Cronkhite from Kansas City:	Hospital Based
Paul Reinert from Springfield:	For profit

Members continuing terms:

Arline Wade from St. Louis:	Consumer representative for the State of Missouri
Carol Gourd from California:	Consumer representative for the State of Missouri
Fern Dewert from St Louis:	DHSS- Health Facility Nursing Consultant

Hospice Advisory Council

The newest members:

Sheila Beussink from Cape Girardeau:	Hospital Based
Brenda Lovelady from Liberty:	Hospital Based

Former members:

Jim Pierce from St. Joseph:	Hospital Based
Mary Dyck from West Plains:	Hospital Based

Members continuing terms:

Debbie Joy from Warsaw:	Home Health based
Roxanne Reed-Wilson from Columbia:	Rural
Yvonne Schwandt from Chesterfield:	For profit

OIG Exclusions Database

It has been brought to the attention of this bureau that all providers receiving Medicare/Medicaid funds are required to check the Office of Inspector General (OIG) Exclusion Database.

A letter from the Center for Medicaid and State Operations, dated January 16, 2009 says "The Center for Medicaid and State Operations (CMSO) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter advises States of their obligation to direct providers to screen their own employees and contractors for excluded persons. This letter specifically...Identifies the List of Excluded Individuals/Entities (LEIE) as a resource providers may utilize to determine whether any of their employees and contractors has been excluded."

The following excerpt is from the Special Advisory Bulletin/September 1999

Titled 'The Effect of Exclusions from Participation in Federal Health Care Programs'

In order to avoid potential CMP liability, the OIG urges health care providers and entities to check the OIG List of Excluded Individuals/Entities on the OIG web site (www.hhs.gov/oig) prior to hiring or contracting with individuals or entities. In addition, if they have not already done so, health care providers should periodically check the OIG web site for determining the participation/exclusion status of current employees and contractors. The web site contains OIG program exclusion information and is updated in both on-line searchable and downloadable formats. This information is updated on a regular basis. The OIG web site sorts the exclusion of individuals and entities by: (1) the legal basis for the exclusion, (2) the types of individuals and entities that have been excluded, and (3) the State where the excluded individual resided at the time they were excluded or the State where the entity was doing business. In addition, the entire exclusion file may be downloaded for persons who wish to set up their own database. Monthly updates are posted to the downloadable information on the web site.

For more information and to review the OIG site, you may access http://www.oig.hss.gov/fraud/exclusion.asp or http://exclusions.oig.hhs.gov

Any agency who employs or contracts with individuals or entities that are excluded from participation in any federal health care program would be a violation of federal law at 42 CFR 424.516 **Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program.**

CIGNA

The following information was received from the Medicare Email List at CIGNA Government Services on March 4, 2011.

In November of 2010, CIGNA Government Services (CGS) was awarded the contract for the Jurisdiction 15, A/B Medicare Administrative Contractor (J15 A/B MAC). At this time, the J15 MAC is not operational; however, during the implementation phase they want to make sure the providers have the most up-to-date information.

If you have questions regarding the transition from your current contractor to CIGNA Government Services, there is J15 toll-free provider implementation help desk to answer questions specifically related to the implementation of the Jurisdiction 15 A/B MAC. The J15 Implementation Helpdesk is now available to assist you as you prepare for transition activities.

For more information about the J15 implementation, call:

Telephone number: **1 (877) 819-7109**

Hours of Operation: **8:30am – 4:30pm CT, Monday - Friday**

Continue to check out their J15 Website for updated news and information throughout the transition period. www.cignagovernmentservices.com/J15.

Missouri Hospice and Palliative Care Association (MHPCA) in conjunction with the Missouri Alliance for Home Care (MAHC) will be hosting a webinar on April 19, 2011 at 10:00 a.m. The purpose of this webinar is to introduce the CIGNA group and to discuss the transition from CAHABA to CIGNA. Issues pertaining to both hospice and home health will be discussed.

For more information please go to: www.mohospice.org.

HOSPICE ISSUES

Social Worker

The bureau received an inquiry regarding whether an agency could hire or contract with an MSW part-time to supervise the BSW until a full-time MSW is found?

Yes, the agency may contract with a part time MSW. The interpretive guidelines at regulation L787 state that each hospice must employ or contract with at least one MSW to serve in the supervisor role as an active advisor. The MSW must consult with the BSW on assessing the needs of patients/families, developing and updating the social work portion of the plan of care and delivering care to patients and families. The supervision may occur in person, over the phone, through electronic communication or other combinations. If the agency contracts with the MSW, then the BSW must be a direct employee because social services is a core service and all core services must be direct employees.

**Please remember that in the state of Missouri, the definition of a social worker is "a person who has at least a bachelor's degree in social work from a school of social work accredited by the Council on Social Work Education." Therefore, the social worker in the state of Missouri must have graduated with a degree in social work. This takes precedence over the Federal regulation that addresses the degree in psychology, sociology or other related fields to social work.

**If the BSW has obtained a baccalaureate degree from a school of social work and is employed by the hospice prior to 12/02/08, the BSW is not required to be supervised by a MSW.

The qualifications for social worker (per Medicare regulations) can be found in **ATTACHMENT A**.

Chaplain

We receive questions frequently regarding the role and qualifications of the hospice chaplain. As you know, this is a very important aspect of hospice and a much needed service, at a very difficult time of life, for both patients and their families.

The state regulations require specific qualifications as listed below:

- The person is ordained, commissioned or credentialed according to the practice of an organized religious group AND
- Has proof of completion of at least 1 CPE unit OR a minimum of a bachelor's degree with emphasis in counseling or related subjects.

The spiritual counselor's personnel file should also include documentation that within 90 days of being hired, training was provided to address common spiritual issues in death and dying, belief assessment skills, individualizing care to patient beliefs and varied spiritual practices/rituals.

This definition is required for ALL persons functioning as the spiritual counselor(s).

One-Hour Response Time

Per 19 CSR 30-35.010 (1) (H), "The hospice shall have written policies and procedures defining access to all services, medications, equipment and supplies during regular business hours, after hours and in emergency situations including a plan for prompt telephone response. Unscheduled non-emergent nursing visits when indicated should normally occur within three hours from the time the need is identified or as agreed upon by the hospice and patient. When clinically indicated, emergent visits shall be made within one hour from the time the need is identified. "

The bureau and the Missouri Hospice Advisory Council have had numerous discussions over the past year regarding this issue. The bureau has now made the determination that the intent of this regulation is:

- When clinically indicated, ***all services*** (not just nursing) must be available within one hour **from the parent agency or the satellite office** (if you have one).

Therefore, if your agency is seeing patients in areas that *nursing* is available within one hour but not *all disciplines*, you may have to give up some of this service area. Your agency may also have to give up some of your territory if your agency is seeing patients in areas where you have a *nurse* who lives within one-hour of the patient's residence but it is not within one hour of your *parent* or *satellite* location.

HOME HEALTH ISSUES

Discharge Summary

The surveyors have recently found problems on survey with agencies having adequate "discharge summaries".

Per 42 CFR 484.2 , Subpart A General Provisions, Definitions, "Summary report means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician."

Per 484.48 Interpretive Guidelines, "The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.

The regulations do not dictate the form to be used as a progress note and/or a summary report. Notations should be appropriately labeled and should provide an overall, comprehensive view of the patient's total progress and/or current summary report including social, emotional, or behavioral adjustments relative to the diagnosis, treatment, rehabilitation potential, and anticipated outcomes toward recovery or further debilitation.

.....The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary reports already furnished to the physician."

What the surveyors have been finding on survey is that discharge summaries are not always including all disciplines and often times are just stating "all goals met". Also, if the discipline discharges the patient earlier in the episode, a summary of that discipline's care is not always included in the discharge summary. These practices do not meet the intent of the regulation.

The Field Clinician's Role in Compliance

In January 2011, representatives from the bureau, conducted a teleconference for the Missouri Alliance for Home Care (MAHC) titled, "The Field Clinician's Role in Compliance". The feedback from home health agencies on the topics presented has been very positive.

The teleconference addressed the most common reasons for home health survey deficiencies as being:

- Incomplete documentation of care and services
- Incomplete or missing physician orders
- Inconsistent documentation
- Vague or unrealistic goals

The surveyors also addressed the top 11 deficiencies and the common practices that result in the deficiencies. In addition, a "Defensive Documentation Tips" document was also given.

Because agencies have expressed to the surveyors that this was a helpful teleconference, the bureau has decided to share the documents provided for the teleconference with all the home health agencies.

Please see **ATTACHMENT B**.

New Survey Process

The Centers for Medicare and Medicaid Services (CMS) recently issued a Survey & Certification Letter (S & C 11-11-HHA) dated February 11, 2011 addressing the Revision of the Home Health Agency Survey Protocols and the New State Operations Manual.

This S&C can be accessed at: www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp.

CMS has developed a survey process for Home Health Agencies (HHAs) that is data-driven, patient outcome-oriented and less structure and process oriented. They have revised and updated Appendix B of the State Operations Manual (SOM) to include the improved survey process and regulations that were revised in 2006. An advance copy of the revised Appendix B can be obtained from the link as referenced above. The final version of this document, when published in the on-line SOM may differ slightly from this advance copy.

New Survey Process Cont.

Some of the highlights of the changes are (non-inclusive):

- Increases the survey's focus on those standards most directly related to patient care processes.
- Increases the use of information gathered from HHA staff interviews
- Minimizes the review of non-clinical record documentation
- Provides more specific guidance for expanding the standard survey to partial extended or extended status
- Adds guidance for issuing standard and condition-level deficiency citations

CMS has tested the changes and believe they support the goal of strengthening the survey process while making it more effective and efficient to assess, monitor, and evaluate the quality of care delivered by an HHA.

The new survey protocol is effective May 1, 2011.

OASIS Clinical by Joyce Rackers

OASIS Documentation Update

With the start of the new year, CMS has posted several updates to OASIS documents and references:

1. CHAPTER 3: On 1/5/2011, the annual revision of the OASIS-C Guidance manual for CY2010 was completed. Because a significant error was found shortly after its posting, CMS posted the revised OASIS-C Guidance Manual and errata sheet on 1/13/2011. For a copy of the updated information please go to www.cms.gov/HomeHealthQualityInits and click on "OASIS User Manuals".
2. Q&As: In January 2011, CMS updated the master copy of all the CMS Q&As. In doing this, they incorporated the past OCCB CMS Quarterly Q&As (Through October 2010). Some of the previous Q&As were also incorporated into the "Response-Specific Instructions" in Chapter 3; therefore, they were eliminated from the master copy. To access the newly updated CMS master copy of the Q&As go to: www.qtso.com and click on OASIS.
3. Quarterly Q&As: On January 19, 2011, the January 2011 Quarterly CMS OCCB Q&As were posted. These Q&As can be obtained by going to: www.qtso.com.
4. Reporting Matrix: OASIS C Process, Outcome and Potentially Avoidable Measures will be transitioned between September 2010 and June 2011. You can access the revised Transition Reporting Matrix Revised 01/04/2011 by going to: www.cms.gov/HomeHealthInits and click on "Quality Measures".
5. OASIS Considerations for Medicare PPS Patients: Due to new billing requirements, this form was updated November 2010; however, errors were noted and the newly updated form was made available January 19, 2011. This document can be found by going to www.qtso.com and click on "OASIS".

January 2011 Quarterly CMS OCCB Q&As

On January 19, 2011, CMS posted the latest Quarterly CMS OCCB Q&As. Some of the highlights from this quarter's Q&As include more clarification on (non-inclusive):

- M1040/M1045 Influenza Vaccine
- M1230 and augmented speech devices
- Whether or not to consider augmented speech devices as verbal expression
- M1300/M1306/M1342 Pressure Ulcers and Surgical Wounds
- M1400-Defining minimal and moderate exertion
- M1500/M1510 Heart failure symptoms question when patient is admitted to hospital for these symptoms but agency not notified
- M1740-Defining "Impaired decision-making"
- Definition of "dressing tasks" when answering M1810 and M1820
- LPNs assisting with the Drug Regimen review
- M2002/M2001 and unsolved medication issues

AND MUCH MORE!

Please print off this set of CMS Quarterly Q&As and share them with your staff. As stated above, these can be accessed by going to: www.qtso.com and click on "OASIS".

Reminder: All other CMS Quarterly Q&As, up to and including October 2010, have been incorporated into the CMS Q&As master copy also found at www.qtso.com.

Removal of HHA Individual User Registration Link Effective April 1, 2011

Self-Registration Link Discontinued

The HHA Individual User Registration link will be removed from the OASIS State Welcome Page on April 1, 2011. After this date, agency users will no longer be able to self-register for HHA personal login IDs.

New Agency Setup Procedures

The requirement for users to acquire personal login IDs will not impact procedures in ACO when setting up a new agency. New agency set-up in ACO should still include the creation of the state assigned agency login ID and password. Creation of the state assigned agency login ID and password, trigger the creation of agency report folders on the QIES state and national databases which are a vital component of the agency reporting process.

Login ID Acquisition

To acquire an Home Health Agency personal login ID, agencies will be required to complete and submit the OASIS Individual User Account Request form. This form will be available on the QIES Technical Support Office website at https://www.qtso.com/accesshha.html
in advance of the removal of the registration link.

Note: All information on the form must be complete in order for the request to be processed. Incomplete forms will be returned to the sender.

Form Completion

Complete the following sections of the form to request a HHA personal login ID:

- Type of request: Check the ‘Create New Access’ checkbox.
- New User Information:
  - User Name
  - User Phone
  - User E-Mail Address

Note: The e-mail address included with the request must be accurate.

- Agency Information:
  - Agency Name
  - Medicare CCN
  - Facility ID (use for new agency test file submission)
  - Agency Physical Address
  - Agency Mailing Address

- Contact Person/Administrator Authorization:
  - Contact Person Name
  - Contact Person Title
  - Contact Person Phone
  - Request Date
  - Contact Person E-Mail Address

Form Submission

When the form is completed, fax or e-mail the form to the QTSO Help Desk (fax and E-Mail information are included on the form). The form will be processed within five (5) business days. Individual users will be contacted via e-mail with the new HHA personal login ID.

Use of Personal Login ID

Once the new HHA personal login ID and password are available, the user will be able to submit assessments and access CASPER Reports immediately. Access to the Validation Reports will be available the following day.

Note: The OASIS Individual User Account Request form is to be used to request access for users who are directly employed by the agency and **not** for OASIS Corporate or Third-Party Service Bureau users.

OASIS Corporate and Third-Party Service Bureau users will continue to use the OASIS Corporate Access Request and OASIS Third Party Service Bureau Access Request forms. These forms will be used to request new Corporate and Third-Party Service Bureau personal login IDs, or to add or revoke agency access from existing Corporate and Third-Party Service Bureau personal login IDs.